Health Services
LOS ANGELES COUNTY

DHS
Isolation/Quarantine Site
Intake Form:

Transportation Disadvantage: Yes or No
Limited English Proficiency: Yes or No
Disability: Yes or No
Ethnicity: Hispanic or Non-Hispanic
Race: African American/African/Americans/Asian/Blacks/Hispanic/Hispanic/Latino Caucasians/Native: Alaskan/American/Hawaiian, Mixed, Others: _____

PEH (People Experiencing Homelessness) **Yes or No**
Anticipated Date of Discharge: _____

Demographics

Patient Name: _____ DOB: _____ Age: _____ Gender: M/F/TW/TM

Language: English/Spanish Only/Other: _____ SSN# _____ Insurance: _____

Patient Phone# _____ Emergency Contact Name & Number: _____/ _____

Address: _____ Patient Present Location: _____

Referral Name/Agency: _____DPH/Homeless Call Center/Other: _____ Contact Number: _____

Case Manager/Social Worker: _____Contact Number: _____ Advance Directive: Full Code/DNR/DNI

Covid-19 Information:

Exposed to known Covid-19 person? Yes or No **Date of Exposure: _____**

Date of Symptom Onset: _____ Covid-19 Test: Yes or No. When: _____ Results: (+) or (-)

Where: _____ Contact Name & Number: _____

Covid-19 Symptoms: Please circle if any: **No Symptoms**
Fever, Cough, Shortness of Breath, Chest Pain, Sore Throat, Chills, Body aches/Malaise, Loss of taste/smell, Nausea, Vomiting, Diarrhea, Loss of Appetite, Abdominal Pain, Fatigue, others. _____

Medical Information: **Allergies: NKDA/NKFA _____ HT: _____ WT: _____**

Vital Signs: T: _____ RR: _____HR: _____ BP: _____/_____ O2 Sat: _____% RA/O2@ _____ (NC/Mask) liters/min. Pain Scale: ____/10

Mental Status: Awake/Alert/Oriented x ____/Confuse/Lethargic/Obtunded. **Skin Issues:** _____

Medical History: HTN/DM Type 1 or 2/HIV (CD4 count____)/CAD/CHF/Asthma/COPD/Emphysema, Hemodialysis (MWF)/(TTHS) – Arranged Y or N?

Pregnant: LMP_____ G___ P___ A ___ Other: _____

Psychiatric History: Anxiety/Depression/Bipolar/PTSD/Auditory/Visual Hallucination/History of Suicide Attempt/History of 5150, Other: _____

_____

Medication List (14 day supplies Yes or No): _____

_____

Social History: **Pets:** Yes or No _____ **ADA:**(WC/FWW/Cane) Yes or No _____ **Placement Needs:** Yes or No _____

Cannabis: How many joint/sticks per day? _____ **Open to MAT:** Edibles Yes or No _____
Tobacco (2.5 risk of Covid-19 complications): **Number of Cigarettes/days:** _____, **Open to MAT** (Nicotine Patch or Vape) Yes or No.
ETOH: Number of beers:/shots/day _____**History of ETOH withdrawal?** Yes or No. **Open to MAT** (Librium or Gabapentin) Yes or No.
Opioids: Prescribed Meds/Street Pills/Heroin/Fentanyl/Other: _____ **Open to MAT:** (Suboxone) Yes or No
Methamphetamine Use: Yes or No_____ **Date of Last Intake:** _____ **Likely Withdrawal?** _____

Date: _____ **Time:** _____ **Nurse Name:** _____**Signature:** _____